and when you consider eating disorders, there's going to be a strong overlap. I don't think it's necessarily a causative factor in every case."

She says a new theory suggesting that anorexia may be a biologic mechanism developed by women when they believe it is not a societally optimal time to reproduce might have some validity. "I don't think that's the whole story by any means, that [anorexia] is purely biological and society has no influence over it. But I think like most things, it's probably a combination of factors. There are so many biological consequences to starvation. It only makes sense that somewhere along the way we learn to use that to our advantage."

She says some of her patients progress through therapy relatively quickly, but others may take years. "Eating disorders are such a chronic problem that if I have patients who are doing particularly well we might just leave things open-ended and I might only see them every 6 months or so. Other patients may be doing very badly and I may be seeing them several times a week."

There is no such thing as an average treatment time, Kostynuk says. "There are some people who don't have a very long history, who do extraordinarily well. There may be some patients who are really chronic, who may have a 20-year history. It's probably not realistic to think they're going to make a complete recovery so what we're trying to do at that point is to manage the illness and prevent as many complications as we can."

Most of her referrals are from female physicians, who tend to recognize eating disorders sooner than their male colleagues. "Women are more likely to ask and patients are more willing to confide in them. Many male physicians can't believe that women are that obsessed with this issue."

A significant proportion of Kostynuk's patients are from privileged backgrounds. "I'm wondering if it's partly because they're coming from a better educated background and their parents are more likely to be recognizing problems earlier and doing something about it.

"I spoke with a GP recently who says he doesn't see many patients with eating disorders," Kostynuk adds. "That's a fallacy. He sees lots of patients who have eating disorders but he's not picking them up. GP's may have more eating-disorder patients in their practices than they realize. Unless they're looking for them and asking the right questions, they're going to go unnoticed."■

Wasted resources a major problem for Argentinian health care system

Ronald Labonte

In the last issue of CMAJ, *Ronald Labonte discussed the cholera pandemic that swept through Latin America in 1991 and 1992. Here he takes a more specific look at the health care system in place in one Latin American country, Argentina, and the need to improve its public health infrastructure.*

"We do not lack the resources to deal with cholera," says Dr. Carlos Ferreyra, president of Argentina's public health association. "Our resources are being wasted in the wrong places."

That waste includes the $3 billion a year that the health care system loses to "bureaucracies and *comisiones*," says Ferreyra, referring to the byzantine and unregulated networks of intermediaries that must be dealt with when doing health care business in Argentina. "That's over 30% of our budget that doesn't go into any health service at all."

Argentina's health system is a complex, three-tiered web that bears some resemblance to health care in the US and has all of that country's well-noted deficiencies in coverage, excess medicalization and unproductive costs. While not typical of all South American health care systems, the Argentinian model poses the rather universal dilemma of whether resources should continue to go into treatment programs, or into primary health care and disease-prevention strategies.

Argentina's first health care tier is a public level managed by federal, provincial or municipal governments. It includes hospitals and community health centres, and provides most of the system's acute care beds.

The second tier, superficially resembling health maintenance organizations in the US, is referred to as the "social insurance" system. Funding is provided through a payroll tax, which the government transfers to more

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than 300 independent agencies called *obras sociales* (social work). Many of these agencies are administered by trade unions and have become large bureaucracies whose primary task is to administer contracts with private or public hospitals and health centres to provide services to agency members.

This second tier is the largest health care provider in Argentina, covering some 65% of the population. (As in the US, the poor and unemployed must avail themselves of less adequate and more strained first-tier public services.) Due to poor administration, however, there is very little cash for the second-tier system.

The workers putatively covered by the second tier end up using the first-tier public system, overtaxing that system's ability to care for those who have no second-tier coverage.

The third tier is the fully private system of hospitals and medical care that is provided on a prepaid insurance basis. Nominally the smallest of the three tiers, this level is economically the most profitable, with much of the profit derived from services provided

Risk cholera poses for travellers low but precautions needed

If you travel to South America the risk posed by cholera is low unless you travel to more isolated areas that lack treated water. The general precautions against gastrointestinal infection prevail: ensure that drinking water is safe. When in doubt, drink bottled water. Avoid ice cubes. Don't eat raw vegetables or unpeeled fruit. Peel your own fruit and scrub it well in safe water. Never eat ceviche, a raw-fish dish. Ensure that all meats and vegetables are well cooked. Avoid food prepared in the streets or markets. Cholera is often transmitted by infected food handlers, so if you have doubts about the health of a cook or other restaurant staff, prepare your own meal or eat elsewhere.

Existing cholera vaccines are only 50% effective for a maximum of 3 to 6 months and are not recommended by the World Health Organization. New vaccines are being tested — researchers are taking advantage of the South American pandemic to test some — but they are not yet available for public use.

under contract to the first and second tiers. It is this system of contracts — the *comisiones* and the bureaucracies it sustains — that wastes much of the country's health care resources.

The service contracts are developed by intermediaries (in effect, labour contractors) hired by the *obras sociales* to purchase hospital and medical services on their behalf. Apart from the commissions earned in this contract process, it is also alleged to be prone to corruption: excessively high price quotations, lower actual contract payments, kickbacks.

Quite apart from these "leakages" and the system's administrative inefficiencies, Argentina is one of the world's most medicalized and least prevention-oriented countries. There is 1 physician for every 435 people, second only to Italy's doctor–patient ratio. (Canada's ratio is about 1:500.)

Argentina graduates more than 5000 new doctors every year. (Canada, with a population only slightly less than Argentina's, graduates about 1800 new physicians annually, and many claim that number is too high.) Doctors dominate all aspects of health care services in Argentina. In Mendoza's provincial tier-one system, for example, 1400 of the 3000 employees are doctors. "We have a proletarianization of doctors," explains Ferreyra, "where many doctors are doing the work of nurses."

This in itself is not a major financial burden; doctors in the tier-one public system earn only slightly more than nurses. However, most Argentinian doctors "work in all three systems," Ferreyra explains, "beginning the morning in the public hospital, working under contract to an *obras sociales* in the afternoon, and running a private clinic in the evening."

This degree of medicalization has led to two conditions antithetical to the struggle against cholera. "Argentinians have come to think of health only in terms of doctors and hospitals," says Ferreyra. "They do not think of prevention. They do not think of self-care. Say you have a hangover — you go to a large hospital the next morning and demand and get immediate, expensive treatment."

Echoing sentiments close to the fiscal hearts of Canadian health ministers, Ferreyra claims there is a strong need for public education on appropriate medical use, and for health care education and health-promotion programs that "don't really exist at all in our country at this time." But this is where the second condition complicates the first.

Unlike Canada, Argentina has no public health infrastructure. There are no public health units, no public health nurses (although some are now being trained) and no place for public health physicians to go, says Ferreyra, "except into the funding bureaucracy or hospital administration." Even if health care resources were transferred to public health prevention programs, there would be no system to administer them.

This is beginning to change. The establishment of an Argentinian public health association 3 years ago is rekindling physician and other professional interest in the World Health Organization's primary health care strategy, and its more politically charged manifesto, the Ottawa Charter for Health Promotion.

That charter defines health promotion as "the process of enabling people to increase control over . . . health," the "prerequisites" for which include "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity." South American countries, not surprisingly, are having no less difficulty than Canada in translating such ideals into specific practice.

In Argentina, and in much of the rest of Latin America, cholera has been, and continues to be, a symbol for the tension between health care and public health. "Cholera has a devastating political and community effect," explains Ferreyra. "It was the last cholera pandemic in the late 19th century that caused many of our countries to develop what sanitary systems we now have. But when cholera disappeared, so did the public health momentum. We fell far behind. Perhaps the return of cholera will allow us to complete our work."■

Sign in memory of fight against yellow fever in San Telmo, Argentina, over a century ago